COMMON APPLICATION FOR RESIDENTIAL CARE

Provider Referred to: _____
Date: _____
Provider Contact Person: _____

PART A - ATTACHMENT CHECKLIST

Child's Full name: **Referring Agency K# or JPO#** _____

LAST	FIRST	MIDDLE	Social Security

Date of Birth	Sex	Race

Tribal Enrollment Number	Tribal Affiliation

Name and Address of Agency Making Referral: _____

Name and Phone Number of Agency Representative Making the Referral _____

Document (original or copies)

1. Birth Verification	Attached	Forthcoming	Not available	Does not apply
Birth Certificate				
Social Security				
Tribal Enrollment				

2. Legal Records				
DPHHS & Probation Dispositional Records				
Custody Orders				
Pre-Dispositional Reports				
Parental Agreement				

3. Educational				
Cumulative Record File				
Immunization Record				
CST				
IEP				
Court Ordered/Informed Consents				
General Education				
Transcripts				
Immunization				
Attendance				
Special Education				
Ed Diagnosis				
Psychological				
CST				
IEP				

ALL INFORMATION IS CONFIDENTIAL

4. Physical Health/Disabilities	Attached	Forthcoming	Not available	Does not apply
Physical Examination/ EPSDT/Well Child Physical				
Immunization Record (unless provided by school)				
Vision Records				
Dental Records				
Nutrition				

5. Mental Health				
Treatment History				
Psychological Reports				
Psychiatric Reports				
Certificate of Need				
UR Certification				
Sex Offender Evaluation				

6. Other				
IV-E Eligibility				
Psycho/Social History				
Reports to the Court				
Discharge Summaries From Previous TX				
SNAP Plan				
Medicaid Card				
Private Insurance Information				
Release of Information – Other than Educational				

7. Additional Information

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PART B - COMMON APPLICATION FOR RESIDENTIAL CARE

(Shelter Care, Therapeutic Foster Care, All Group Home Care, Residential Treatment)

Identifying Information

Child's Full name: **Referring Agency K# or JPO#** _____

_____ _____ _____
LAST **FIRST** **MIDDLE**

_____ _____ _____
Height **Weight** **Religious Preference**

_____ _____ _____
Eye Color **Hair Color** **Identify Characteristics/Scars**

Child's current location or placement: _____

Agency and County of financial responsibility: _____

I. Referring Information

1. **Briefly describe your impressions of this child including present problems:** _____

2. **Briefly describe the child's strengths:** _____

3. **What length of time do you anticipate will this child be receiving services on this level of care?**

4. **Discharge Plan:** _____

II. Custody Status

Who has custody of this child?

Mother	☐ Yes	☐ No				
Father	☐ Yes	☐ No				
Guardian	☐ Yes	☐ No				
DPHHS	☐ Yes	☐ No	If yes, is it:	Permanent	☐ Yes	☐ No
				Temporary	☐ Yes	☐ No

Have parental rights been terminated?

Mother	☐ Yes	☐ No	☐ Unknown
Father	☐ Yes	☐ No	☐ Unknown

Will family members participate in therapy? ☐ Yes ☐ No

Can this child return home?

Permanently	☐ Yes	☐ No
For Visits Only	☐ Yes	☐ No
Not at All	☐ Yes	☐ No
Unknown	_____	

Parents(s) **Mother:** _____ _____
Name Phone #

Address: _____

Father: _____ _____
Name Phone #

Address: _____

Step Parent(s) _____ _____
Name Phone #
Address: _____

Step Parent(s) _____ _____
Name Phone #
Address: _____

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Guardian _____ _____
Name Phone #
Address: _____

Siblings	**Name**	**DOB**	**Residence**

Other Individuals significant to this child

Name	**Relationship**	**Address**	**Phone**

III. Education

Highest grade completed: _____
Currently Enrolled? ☐ Yes ☐ No
District of Residency: _____
District of current enrollment: _____
Educational Needs:
Regular Classroom: _____
Full Special Education: _____
Part Time Special Education: _____
Day Treatment: _____
Other: _____
Does child have a Surrogate? ☐ Yes ☐ No
If "Yes", provide name, address and phone number: _____
_____
_____

IV. Juvenile Justice History

Does this child have history of involvement with the juvenile justice system? ☐Yes ☐No ☐Unknown

If "Yes": Number of referrals to Juvenile Probation: _____
Number and types of Adjudications: _____
_____
_____
Offenses: _____
_____
Present Status: _____

V. Special Needs, Behaviors, and Programs

Is child a danger to self? ☐ Yes ☐ No ☐ Unknown
Has this youth had a. Suicidal gestures ☐ Yes ☐ No ☐ Unknown
b. Suicidal attempts ☐ Yes ☐ No ☐ Unknown
Suicide Risk Assessment: ☐ High ☐ Moderate ☐ Low
Other: Explain: _____
_____
Is child a danger to others? ☐ Yes ☐ No ☐ Unknown

If "Yes", explain: _____

Number of runaways from home: _____
from placements: _____

History of fire setting? ☐ Yes ☐ No ☐ Unknown
History of cruelty to animals? ☐ Yes ☐ No ☐ Unknown
History of Explosive Behaviors? ☐ Yes ☐ No ☐ Unknown

ALL INFORMATION IS CONFIDENTIAL
Has this child been sexually abused? ☐ Yes ☐ No ☐ Unknown
If "Yes", briefly explain: _____

Is this child a sex offender? ☐ Yes ☐ No
If "Yes", what is the risk to re-offend? ☐ High ☐ Moderate ☐ Low
Explain sexual offense history: _____

Special Needs Program
Maternity ☐ Yes ☐ No If "Yes", due date: _____
Independent Living ☐ Yes ☐ No
Other ☐ Yes ☐ No
If "Other" explain: _____

VI. Placement History

Has the child been placed away from home before? ☐ Yes ☐ No
If yes, how many? _____

Placement History: (End with most current)
This section is designed to reflect disruptions or changes in the child's living situation. Include all agency out of home placements, independent placements, adoptive placements and breakdowns. If the information is available in the social history, make that notation. You do not have to complete this section if the information is available on another document. Make the notation that the document is attached.

Name of Provider/Relative/other	From - To	Reason for Termination

VII. Substance Abuse

Does child have substance abuse history? ☐ Yes ☐ No ☐ Unknown
If "Yes", indicate type and degree: _____

Has child received chemical dependency treatment? ☐ Yes ☐ No ☐ Unknown
If "Yes", what kind? Inpatient ☐ Yes ☐ No ☐ Unknown
Out Patient/Community Based ☐ Yes ☐ No ☐ Unknown
Current Status: _____

VIII. Abuse/Neglect History

Does child have a history with DPHHS? ☐ Yes ☐ No If "Yes", how long? _____

Does this child have a history of abuse/neglect? ☐ Yes ☐ No ☐ Unknown

If "Yes", to either or both questions, describe: _____

Does child have a Guardian ad Litim? ☐ Yes ☐ No

If "Yes", name, address and phone number: _____

ALL INFORMATION IS CONFIDENTIAL

IX. Physical Health/Disabilities

Does this child have a diagnosed or suspected health condition or disability? ☐ Yes ☐ No ☐ Unknown

Describe the condition/disability and treatment required if any: _____

Does the disability fit the definition of Developmental disabilities as defined by MCA?

☐ Yes ☐ No ☐ Unknown ☐ NA

Is the child currently receiving DD services? ☐ Yes ☐ No

If "Yes", describe the services and provide the name and address of the provider: _____

Does the child receive any medications for this condition/disability? ☐ Yes ☐ No ☐ Unknown

If "Yes", specify drug, dosage, length of time on this medication: _____

Name, address and phone number of prescribing physician: _____

Does child/youth receive SSI? ☐ Yes ☐ No

If "Yes", amount: $ _____

Payee: _____ _____

Name Address

Does the child require physical therapy for this disability/condition? ☐ Yes ☐ No ☐ Unknown

If "Yes", specify type, frequency, and providers name and address: _____

Specify any additional information which is pertinent to the physical condition/disability of this child:

X. Mental Health/Disabilities

Does this child have mental health needs which require treatment? ☐ Yes ☐ No ☐ Unknown

If "Yes", date of most recent psychological/psychiatric evaluation: _____

DMS III-R Diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Have medications been prescribed? ☐ Yes ☐ No ☐ Unknown

If "Yes", specify drug, dosage, length of time on these medications: _____

Name of prescribing physician(s) and phone numbers:

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XI. Other

Please provide any additional information you feel is pertinent:

Signature of Agency Representative Completing the form

Date

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DATE: _____

TO: _____
(Placing Agency)

FROM: _____
(Service Provider)

RE: _____
(Name of child/youth)

_____ , referred by your agency, has been

☐ **Accepted for services**

☐ **Denied admission**

Reason for Denial: _____

_____

_____

Recommendations: _____

_____

_____

☐ **Placed in Pending Status**

Reason for Pending Status: _____

_____

_____

Recommendations: _____

_____

_____

_____	_____	_____
(Signature)	***(Title)***	***(Date)***

CONSENT TO RELEASE INFORMATION

I/We, _____ Parent(s) or Guardian(s) of _____
Parent(s)/Guardian(s) Name *Child's Name*

give my/our permission to the following:

Name	Address

to release to the following:

Name	Address

All medical, dental, psychiatric, psychological, educational, evaluations, and/or other reports pertaining to my/our child. I/we understand this information will be used by the receiving agency for the purpose of case planning, treatment and/or:

I/we understand the information will be held confidential by the receiving agency except for the above stated purposes. This consent expires upon release of the information to the receiving agency or six months from this date.

Parent or Guardian	Date
Parent or Guardian	Date
Witness	Date